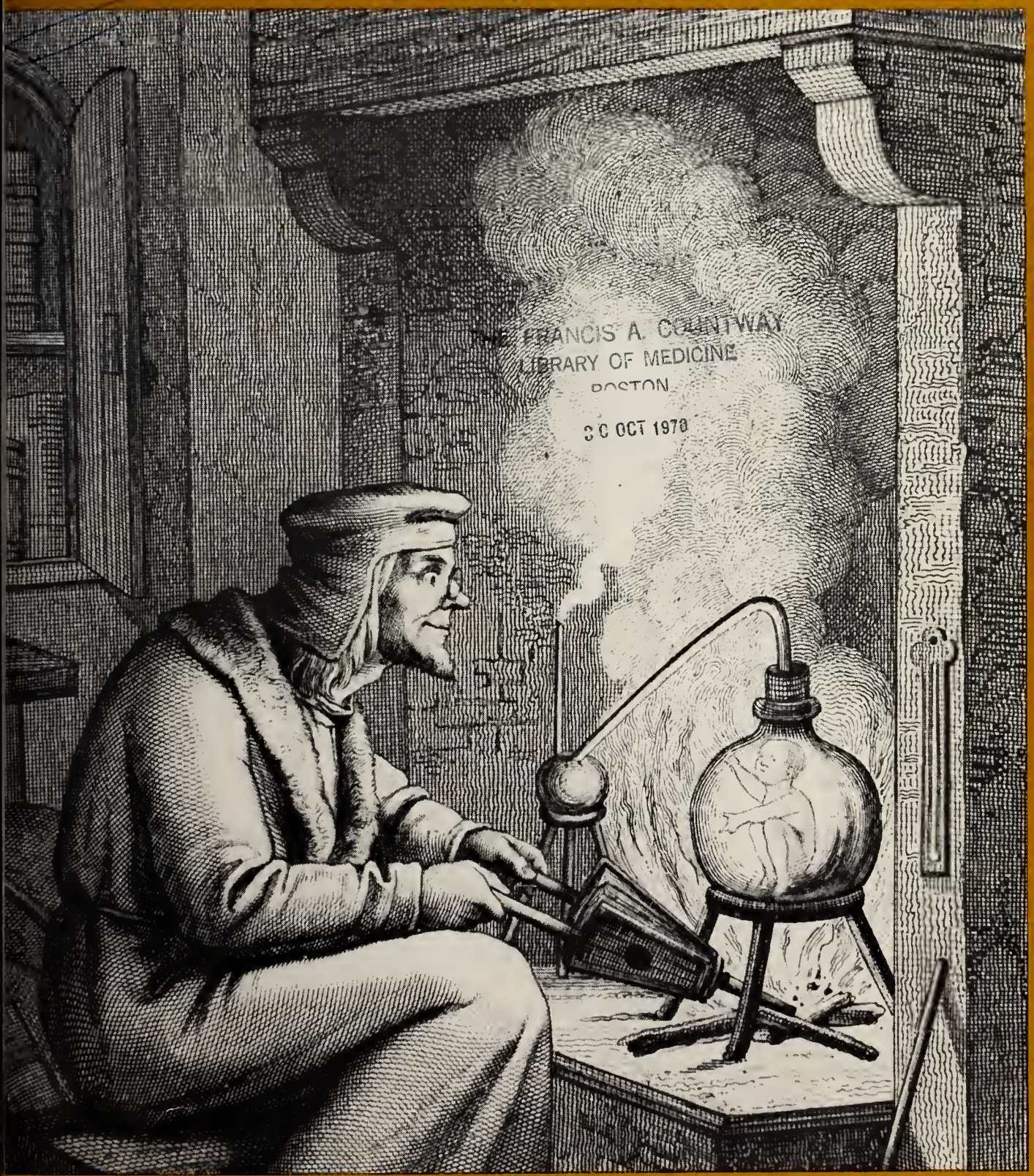
Medical Alumni Bulletin

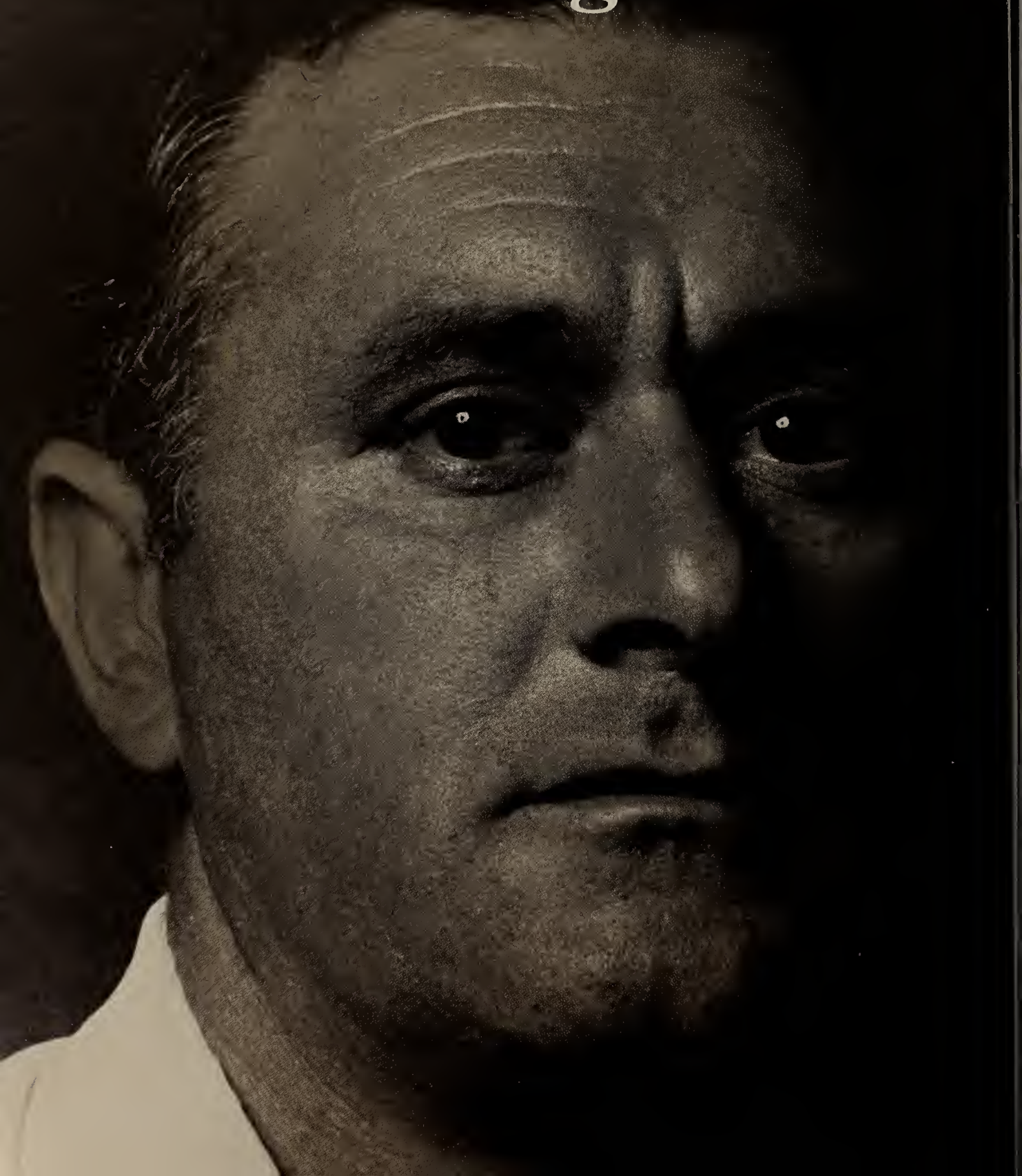
HARVARD

Sept./Oct. 1970



The negative power of anxiety...

This man thinks he may never work again.



The patient who has had a myocardial infarction is usually advised by his physician to avoid emotional excitement. All too often his family, acutely concerned, transmits its anxiety to him, urging him to "rest, rest."

How anxiety may interfere

In a study of 336 males who had suffered at least one myocardial infarction, Sigler[1] reports that manual workers showed the lowest percentage of patients returning to work, compared to clerical workers, business and professional men. The author notes that in many cases the mere apprehension that "return to work would shorten life prevents the patient from resuming activities." It is also well known that emotional disturbance is probably the most common cause of cardiac disability in postinfarction cases.[1]

The anxiety factor in both *coronary* and *precoronary* patients has recently been discussed by Thomas,[2] who suggests: "Intensive investigation of the sources and kinds of anxiety, and how destructive forms of anxiety can be identified and relieved may be the next important step in the prevention of coronary heart disease."

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References: 1. Sigler, L. H.: *Geriatrics, 22*:(9) 97, 1967. **2.** Thomas, C. B.: *Johns Hopkins Med. J., 122*:69, 1968.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

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Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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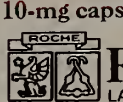

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Townsend, E. H., Jr.: New England J. Med. 258:63, 1958.

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COVER: The Seiberitz engraving depicts the birth of the homunculus, and is one of the Faust illustrations. In this issue, the *Bulletin* covers some of the aspects of abortion. Dr. Reid's article is based on his speech to the American Association of Planned Parenthood Physicians. Dr. Asher's article is based on his speech at the 5th annual meeting of Atlanta Planned Parenthood.

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The opinions of contributors to the Bulletin *do not necessarily reflect those of the Editorial Staff.*

Population Control: Medical and Public Policy

by Duncan E. Reid, M.D.

As the decade of the Sixties recedes into the past, a sense of fearsome uncertainty continues to prevail. One would like to believe that this uncertainty is born of society's search for a quality of life that the advances in technology and the biological sciences could provide for all mankind.

Surely it has long been appreciated (Genesis III:22) that as man gains greater insight into the secrets of nature, he may threaten his very existence. This possibility has arrived with the dawn of the nuclear age, and as the birth rate exceeds the death rate in nearly all countries, resulting in a state of uncontrolled population growth with all its socioeconomic and political connotations.

The contributions of this nation to the welfare of mankind within and beyond our shores will be determined by our national condition. Moreover, it is contended that any threat to our national security is more likely to be determined from forces within, rather than from without, our boundaries, arising from the socioeconomic inequities and pressures of unlimited population. It is conceded by many that if poverty, with all of its social evils, is to be eliminated by peaceful and rational means, the size of our population should not increase, at least for a time.

What the optimum population for this nation should be has received the attention of economists, social scientists, general theorists, and those in the medical profession. The discussion and writings have ranged from the impact of large populations on the daily life of the individual, to relating the rate of population growth to the gross national product.

A population of 300 million is projected for this nation by the turn of the century. We seem to befoul our nest thoroughly with a population of 200 million, dramatized, perhaps, by referring to the Seventies as "the decade of ecology." It has recently been reported that the birth rate had an upward swing for the year 1969 in New York City and the state at large. Considerable space was given to reporting the programs of family planning. Despite these all-out efforts, the birth rate exceeded by some 50 to 60 percent that required to stabilize the population. This indicates that present methods of birth control are, to say the least, inadequate.

Those who would argue that impressive advances in agricultural technology may support a greater population will have to reckon with the fact that the United States, accounting for only six percent of the world population, consumes an estimated 35 to 50 percent of the world's resources. But do we have the right? For in the face of this abundance, is it not a national disgrace if we permit poverty and want to exist not only within but also beyond our own shores? Also, what is referred to as "population implosion" connotes that 70 percent of the population resides on two percent of the land; this also adds to the national dilemma.

This is hardly a new subject. Certainly the Greeks were concerned with population size when they asked what men should live for. When defining the form of society required for the citizen to realize the best of his nature and innate potential, Plato, in his *Republic,* also written in a period of war and revolution, was cognizant of the necessity of "keeping the number of the citizens as constant as possible, having regard to losses caused by war, epidemics, and so on." This utopian state was to have 5,040 citizens, each holding "one unalienable lot of land." Despite this seemingly manageable number, population control was stated to be a problem. Long periods of celibacy were suggested as the solution, a method that appears to be obviously unacceptable. Rewards and privileges were used to enhance motivation to control population size. Also, it was recognized that each of the social classes, as defined, must participate proportionately in limiting the population; otherwise, there could be a dysgenic effect.

In the modern context, it has been suggested that motivation be replaced by the term "general will" as a means of negating the "unrestricted freedom to procreate." It has further been suggested that the older idea of rewards as a deterrent to excessive reproduction be grafted onto social security, together with a bonus system, and "thus provide parents with the incentive not to exceed what is for them the largest number of children, presumably two and not more than three." It is also proposed that the right to parenthood is a privilege and should only be exercised by individuals capable of meeting the responsibilities of parenthood. However unrealistic this appears at the moment, any policy governing population size must consider these principles.

Immediately voices will be raised questioning the fate of the child who exceeds the number of children that a family may have to maintain the population at its present size. This applies particularly to those economically disfranchised and their relation to the welfare system. Of course, no child should be penalized when, in fact, he has not been consulted. Although astounded by his own environmental luck, Henry Adams posed the question whether he would have cared to play the game of the 20th century had he known the risks at stake.

It seems inescapable that any program concerned with population control must operate within a uniform welfare or bonus system, attainable only at the federal level. Besides encouraging restriction of family size, a federally-sponsored

welfare or bonus system, with consistent benefits in each state, might provide some impetus for the decentralization of the overpopulated urban areas, also a desirable objective. All of this has political, economic, and social overtones. Most politicians, and many citizens, refuse even to contemplate the problem.

Certainly there are no easy or quick answers. A balanced and stable population is difficult to attain until the incentives and motivation to permit a rewarding and useful life for every citizen are provided through education and equality of opportunity. This is the more difficult to secure in a democratic society where threats, reprisals, and decrees are unacceptable. Hence, in the course of the ecologic struggle, compromises must be sought and exceptions made.

The economic approach alone has limitations, even in developed countries, until such time as a totally effective method of pregnancy control is available. In the intervening period, despite psychological and minimal physical risks, if the population is not to exceed the present 200 to 210 million, consideration must be given to abortion as a means of population control. Certainly, within this context, it can no longer be ignored.

Furthermore, as has been aptly stated, the generals (in this instance the social planners both in and outside the profession) should not be permitted to chat and sip sherry in their tents while those who must ultimately be responsible for implementing the programs of population stabilization remain mute. The magnitude of any program of population control and its social and medical requirements must not be minimized. Whenever abortion is suggested as a method of population control, little, if any, attention is given to the logistics of the problem, in terms of the number of patients involved, and who is to be medically responsible.

In making a prediction of the number of individuals who will seek an abortion annually, account must be taken of social scientists who state that conception control is, of course, the first line of defense in population control, with abortion being the second. Surely if the second line of defense is available, and abortion becomes a public health policy as a means of population control, the first will be more of a Maginot line, at least for a period of time. However, when the public is sufficiently informed and realizes that artificial abortion is subject to complications, even when performed under proper supervision and surgical environment, there will be a greater incentive toward conception control. This is supported by the decrease in recent years of the number of abortions performed for population control in Japan. Besides the complications that may arise at the time of pregnancy termination, albeit few, repeated abortion may give rise to a state of relative infertility through the syndrome of the incompetent cervix and even less understood factors such as tubal dysfunction. With respect to relative risk, it must be recognized that the maternal mortality for this country also includes medical and surgical or nonobstetric causes that complicate pregnancy. The accuracy of the vital statistics of any country is subject to question, but these should not be slanted in an overzealous desire to win a debate. To place one risk against another in this area may be a hazardous pastime, because reporting is somewhat superficial and subject to personal interpretation.

WHAT is the status of so-called medical or artificial abortion at the present time? The majority of physicians would agree that pregnancy is contraindicated for medical reasons where it may endanger the life, reason, and health of the mother. One might justifiably include the multiparous patient in whom the pregnancy risk is increased. Also, most physicians believe that a medical abortion is indicated where the fetus may be grossly or genetically abnormal. Rape and incest are acceptable indications. It is suggested that the minor deserves to be given special consideration based on whether the immature individual has the capability to make a critical discrimination and judgment. The same reasoning may apply in making a determination and decision as to the advisability of a medical abortion for the psychiatric patient. Unquestionably, many unwed patients, especially teenagers, are psychologically disturbed; this is a major

factor in their becoming pregnant. In passing, it might be noted that the Commonwealth of Massachusetts is one of the few states that has no statute governing therapeutic or medical abortion. However, except for the first indication, what remains unanswered is whether or not the remaining indications, as listed, would prevail if tested in the courts. Regardless, all of this hardly answers the larger problem of population stabilization.

Thus, despite the fact that the statutes governing medical abortion have or are being revised in many states, the question still remains — for what purpose? There are states with highly restrictive statutes, and it seems likely that in the present social climate, the courts of these particular states would interpret the statute in accordance with the majority of current medical opinion. Even where the law has been extended, the number of legal abortions will not increase appreciably, if the procedure is performed within the law in its most liberalized form. Exceptions are the states of Hawaii, New York, and perhaps Oregon, whose law was drafted following the statement of The American College of Obstetricians and Gynecologists, which is similar to the British law.

That is not to say that abortion is not being performed with increased frequency, but often under the guise of psychiatric indications recently diagnosed. Hence, medical abortion, as it is now being practiced, is all too often economically discriminatory and can become a corruptive influence in hospital practice. The latter may not be removed, and indeed may be enhanced, if the law states that an abortion may be performed on a decision reached by the patient and her physician. If the issue is truly the necessity for abortion as a means of population control, is it not time to stop modifying and devising new laws and to face the issue squarely? Therefore, it is suggested that abortion be considered a voluntary act that relates to the general welfare — stabilization of the population.

This is a national issue, indeed an emergency comparable to a situation involving our national security. If it falls within the framework of the "general welfare," let Congress and the Supreme Court make the most of it. Time does not permit us to wait for the action of each and every state. To be effective, all states must be equally involved.

It is difficult to state unequivocally the extent of such a program, for, as indicated, it will depend to a degree on more effective measures of conception control and their use. When this nation's population is compared with others that use abortion to limit population, at least a million to a million and a half abortions would have to be performed annually in order to reduce the birth rate from 18 to 12-13 per thousand, thus maintaining the population at the present level. Certainly such a program goes much beyond that of a one-to-one relationship of patient and physician. Indeed, the latter will be unwilling to make decisions where masses of patients are involved, nor should he be expected to do so. Also, it should be said that this is not a responsibility for one special group or area of medicine — obstetrics and gynecology — but rather the entire profession. All surgically oriented staff members must participate in accordance with their personal attitudes and beliefs.

Many, if not most, hospitals, both voluntary and public, will not participate in this program for a variety of reasons that originate from such sources as staff, boards of trustees, and general social attitudes. In a free society this is as it should be. Moreover, consistent with a democratic society, it should be clearly understood that forceful means to procure an abortion are absolutely medically unacceptable if that is what is meant by "abortion on demand." Also, it is unrealistic to expect that the program could or should be carried out entirely in those hospitals willing to participate. If a national program is instituted, it must be under some arrangement whereby the hospital is a back-up or referral facility.

Until such time as the population can be stabilized by effective medical means, it is recommended that special centers, each with a few beds, be geographically located adjacent to a general or women's hospital. Specially-trained paramedical personnel would perform the abortion under physician supervision. This should be acceptable, for it is commonly stated by both physicians and laymen that the procedure is quickly and easily performed, and without appreciable risk, at least during the first 10-12 weeks of pregnancy. Should there be any complication, a consultant is quickly at hand with the hospital as a back-up facility. Patients in the special units could leave within a few hours after the procedure, but should they require any subsequent attention, they could be referred to the hospital. Follow-up and, in many instances, rehabilitation services must be included.

Undoubtedly this service should be public-health sponsored, supported, and managed, preferably by the Department of Health, Education, and Welfare. To guard against discrimination and eliminate some of the pernicious practices that now exist, the fee for service should not apply. This approach would remove any socioeconomic discrepancies; every woman could avail herself of this service.

Under this arrangement, only patients at medical risk as enumerated, including individuals under 16 years of age, would have the abortion performed in the hospital and by a physician. In this instance, the medi-

cal economics should be hospital-controlled. Accordingly, by this system, the terms "abortion on demand" and "unwanted pregnancy" would have no medical relevance, or, should they have meaning, would apply to the program designed for population control.

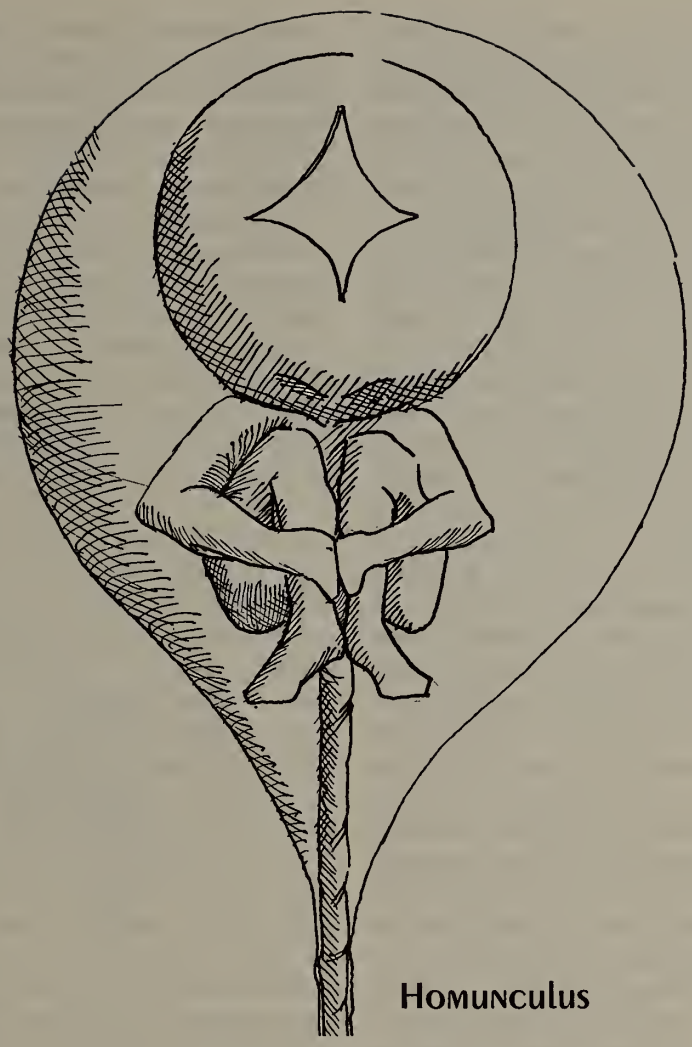
Hopefully the day is not far away when the surgical method will be replaced by an effective medical method that is applicable to world usage, thus making the term population control truly meaningful. There is promise that this is a possibility.

The lowest incidence of mental retardation and cerebral palsy is found in parturients between 18 and 30 years of age who deliver no more than four offspring properly spaced. This statement has socioeconomic as well as medical implications. There might be a further decrease if the number of offspring were two rather than four, a family size that would stabilize the population.

Consistent with our national purpose, if we truly believe in a state of perfect freedom for the individual, it begins by being born without handicap. Thus born, the opportunity to exercise the privilege and the responsibility of perfect freedom will depend upon the condition of the physical and social environment dictated in large measure by population size.

It follows that from medical and public policy, a medical care system must be developed that will assure the country that the appropriate number of citizens are born without handicap and are afforded the opportunity to make their contribution to the service of mankind both within and beyond our shores.

Dr. Reid is William Lambert Richardson Professor of Obstetrics, Kate Macy Ladd Professor of Obstetrics and Gynecology, and Head of the Department of Obstetrics and Gynecology at Harvard Medical School.



Homunculus

Abortion in Atlanta

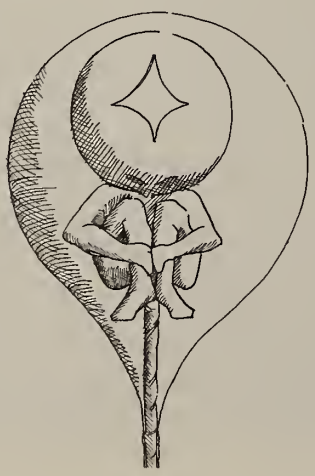
by John D. Asher '67

THIS is the first time that abortion has been discussed in Atlanta within the overall context of Planned Parenthood. It seems something of a paradox that a revolutionary organization such as Planned Parenthood, which began as a radical feminist movement, would for so long have been so silent on the topic of abortion. It is not as if abortion were a new invention; in fact, there is no way of telling whether contraception or abortion is the more antique form of birth control.

Anthropologists, such as George Devereux, have found that both abortion and contraception were practiced in some form by all primitive peoples. In spite of its antiquity, abortion does not hold nearly the position of respect in the Planned Parenthood movement that contraception does. I would propose two possible sources for this unfortunate state of affairs. The first is the latter-day persistence of the homuncular theory of human development. The 17th century concept of fertilization was that small, oddly proportioned human beings, called homunculi, were transported live in the male sperm to find a convenient spot in the female uterus, there to spend the next nine months growing larger and larger until ready for delivery. To my mind, this was and remains a

very reasonable theory. Certainly much more reasonable than to think that two cells from two totally different human beings could unite, then begin to divide, pass through a stage the size of a pin, then a blackberry, and end up weighing approximately eight pounds. Who could have guessed that those original two cells would turn into various structures like a heart, or an eye, or a bladder? It really made much more sense to suppose that a tiny, fully-formed human being was deposited and simply got larger. To hypothesize human development, as modern embryology has demonstrated it, would have required a much greater faith in nature than was common in the 17th century. However, our thinking today on abortion, in spite of all our scientific knowledge, still seems to be greatly influenced by the homuncular theory. Thus we speak of "murdering the fetus." When we talk that way, we are thinking about that little homunculus sitting in that uterus. We imagine him as a small, helpless child sitting in the womb growing larger when, in fact, we know that early in pregnancy we are talking about a group of cells, a tissue mass, in short, an embryo and not a child, not a miniature human being, but a collection of nuclei and protoplasm with the potential to become a human being — the same potential that every sperm and every egg has to unite and become a human being.

There is another reason why abortion does not hold the position of respect in the Planned Parenthood movement that contraception does. The decision to grant an abortion is molded by society's judgment of the circumstances of conception. In deciding whether an abortion should or should not be done, a great deal of importance is attached to the question of whether the woman should or should not have performed . . . should or should not have been a partner to . . . should or should not have . . . **copulated.** We see in all abortion laws, newly enacted in eleven states of this country in the past three years, that if a woman is raped, then it is her unquestioned right to have an abortion. In fact, in Mississippi, the entire new addition to the abortion law consists only of allowing abortion for rape. Our cultural feelings about sex and coitus have colored our rational thinking about pregnancy and abortion.



In the foreword to the recent *Advances in Planned Parenthood, Vol. IV,* Howard C. Taylor, Jr. made some comments pertinent to the abortion issue. He said, "The problem of high birth rates and rapid population increase is now defined in economic, sociologic, or demographic terms. With this trend has come the assumption that the problem may be solved chiefly through the implementation of these sciences. I believe this to be true to only a limited extent, that decisions about reproduction must ultimately be made by the individual and, therefore, that the physician's involvement, responsibility and opportunity are constantly growing." No system of reproductive control presently available offers the woman as much individual choice as does abortion; unfortunately, the responsibility for and involvement in this method has been avoided, in fact, shunned, by the physician and by Planned Parenthood. Since, as Dr. Taylor said, it is the individual's decision in the end that makes the difference, the lack of involvement by the physician has not resulted in the nonusage of abortion; rather, as we all know all too well, it has left the field to the untrained, the unskilled, and the unscrupulous. Who has suffered most from this abdication of medical responsibility? The unschooled, the unprivileged, and the "nonwhite."

In 1898, 18 years before Margaret Sanger opened her clinic in the Brownsville section of Brooklyn, a gentleman named Freud made a statement worth repeating today. He said, "It would be one of the greatest triumphs of mankind, one of the most tangible liberations from the bondage of nature to which we are subject, were it possible to raise the responsible act of procreation to the level of a voluntary and intentional act and to free it from its entanglement with an indispensable satisfaction of a natural desire." "To raise the responsible act of procreation to the level of a voluntary and intentional act" sounds very much like "every child should be a wanted child" and "to free it from its entanglement with an indispensable satisfaction of a natural desire" brings us back to the relation between coitus and pregnancy.

Since it is possible to raise the responsible act of procreation to the level of a voluntary and intentional act, and since it is possible both theoretically and technologically to make every child a wanted child, let us examine some of the pros and cons about this method of birth control called abortion. First, the advantages:

1. Like the IUD and the Pill, it is not coitus-related;

2. It is 100 percent effective; only abstinence is as effective though apparently becoming less popular;

3. Motivation is not a problem, since abortion requires hindsight rather than foresight; it is therapeutic rather than preventive medicine;

4. Properly and promptly performed, it has a low morbidity and a low mortality, the mortality being about the same as that of thromboembolic complications associated with the Pill, namely, 3-4 deaths/ 100,000 patients.

Second, the disadvantages:

1. To some individuals, it is morally objectionable because it involves "murder" of the fetus;

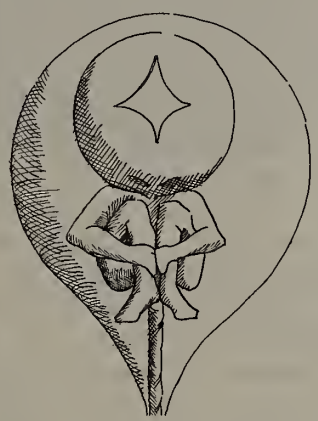
2. It is alleged by many that the use of abortion will increase promiscuity;

3. It is alleged by others, and these often are members of the Planned Parenthood movement, that the adoption of abortion as a birth control measure would diminish the need and use of other more conventional methods of birth control.

There are many more objections often cited that I will not go into here except to list a few examples, such as the feared deleterious effects on obstetrical and gynecological residency programs, the fear that abortions are a Communist plot, that they are a Nazi plot, and that abortions will increase mental illness. Individuals who voice these fears often use key, highly-charged phrases that have great emotive power and which should be recognized. Some of these are "legalized abortion," "abortion on demand," "murder," and "promiscuity."

LET us examine these three "disadvantages" of abortion as a method of birth control It is well to remember that abortion has been legal in this country for more than 100 years. The primacy of the mother's life was established by 19th century state laws and has never been challenged. The laws that have been passed since 1967, starting in Colorado, have merely broadened the categories under which abortion is legal. The question has always been under what circumstances, not whether, the fetus could be removed from the woman's uterus. We usually speak of the mother undergoing an abortion. "Mother" is a loaded term. The term "mother" implies a child. The term "child" implies murder or infanticide.

The argument about increased promiscuity is an old one that I will not belabor. In the 1930's, it was claimed that treatment of venereal disease would increase promiscuity. In the 1950's, it was claimed that the Pill would increase promiscuity; this fight is not over, and already a major battle of the 1970's is the claim that sex education will increase promiscuity. It is not surprising that abortion has been accused of having the same disastrous results. As I said, "promiscuity" is a loaded term. I think the tendency more and more around the country, as demonstrated by the excellent adolescent pregnancy programs that have been instituted in many cities, including Atlanta, is to accept the reality of sexual activities and to try and minimize their harmful results.

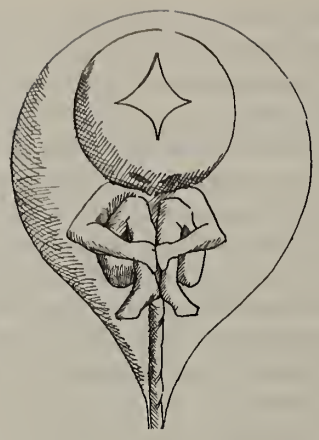


The question of the relationship between abortion and other methods of birth control is not an easy one. In countries where answers could be found, such as in Eastern Europe and Japan, they are not available. In our series of 90 women at Grady Memorial Hospital, who were treated either with therapeutic abortions or for complications of nonhospital abortions, over 75 percent of them accepted the IUD or the Pill before leaving the hospital. Most of those 25 percent who did not accept contraception either did not need it, or thought they would not require it. My impression from talking to the majority of these women is that abortion, whether hospital or nonhospital, serves as a strong force in motivating women to seek other forms of birth control for the future.

Finally, I would like to mention some of the recent changes in abortion laws and their effect on practice. I think we tend in this country to place a great deal of naïve faith in laws. For example, in 1954, when the Supreme Court ruled that segregation was against the law, many people assumed that, as a result, segregation would disappear. Similarly, when new abortion laws were passed, many people assumed that it would be easier to get abortions. Let us look at the wording of some of these laws and then see what effect they have had. In California, the new law said that you could perform an abortion if "there was substantial risk that continuance of the pregnancy would gravely impair the physical or mental health of the mother." In Georgia, you can perform an abortion if "a continuation of the pregnancy would endanger the life of the pregnant woman or would seriously and permanently injure her health." In Maryland, you can perform an abortion if "continuation of the pregnancy is likely to result in the death of the mother or there is substantial risk that continuation of the pregnancy would gravely impair the physical or mental health of the mother." Now, if you are confused with terms like "substantial risk," "gravely impair," "endanger," "seriously injure," "likely to result," you are not alone. It does not take an astute legal mind to realize that these sections of the three laws really say the same thing, and what you do as a physician, a hospital committee, administrator, or resident depends on how you interpret those laws. In all of the clauses, the key word is health, whether physical or mental, and everything boils down to your definition and interpretation of that word. The woman's life is not often in jeopardy. The World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity." For every therapeutic abortion that was done in Georgia on a proportional basis, there were ten therapeutic abortions done in the state of California the first year after the law was enacted. For every one abortion done in California, there were four and one-half done in Maryland, which means that for every abortion done in Geor-

gia, 45 were done in Maryland. The Johns Hopkins Hospital, in a regular monthly report, has averaged over 100 therapeutic abortions per month since July 1969. They deliver approximately 2,000 babies at that hospital annually, and they are doing about as many abortions every month as the state of Georgia, with 90,000 deliveries, does in one year. To give you another example how, in Howard Taylor's words, "the opportunity to become involved and responsible" has been carried out in other sections of the country, there is the San Francisco Planned Parenthood experience. We know of several girls who have come to our Family Planning Program here in Atlanta looking for abortions who have found safe, legal abortions through the help of Planned Parenthood in San Francisco. This is obviously a service that is not available to the financially indigent whom we are trying to serve at Grady; however, in San Francisco, pregnancy counselling and abortion referrals, at no charge, are an integral part of the Planned Parenthood affiliate operations. They have approximately 50 obstetrician-gynecologists who are cooperating with them by performing abortions; they have approximately 70 psychiatrists who are cooperating by determining whether the patient's health, that is, her opportunity to develop "a state of complete physical, mental and social well-being," would be endangered by the pregnancy.

As many of you know, a bill was presented in the Georgia Legislature to abolish the liberal Georgia Abortion Law by repealing it, thereby leaving the decision in the hands of the individual physician and the patient. Rather than "abortion on demand," this is termed "abortion by choice" — by choice of the patient and physician. Such a bill nearly passed the Kansas Legislature last year, and I have no doubt that in the next year or two, there will be a state that repeals its abortion law; by the end of this decade, I would venture to say the majority of states will have repealed their abortion



laws. These actions may, of course, be obviated by the Supreme Court, which could rule all present abortion laws unconstitutional.

We are dealing then with the question of the Future. Perhaps I dispensed with the Present and the Past so rapidly that you did not notice. At the present time, just as in the past, abortion in Atlanta as a method of birth control is, by and large, under the control of the unlicensed, the untrained, and the unscrupulous. As long as this situation remains unchanged, our maternal mortality figures will continue to reflect the fact that about one-fifth of the maternal deaths in the state of Georgia in the past decade were due to abortions performed illegally out of the hospital, and of that number, 75 percent were in the black population. This is the same population excluded by financial and social considerations; first, from legal abortions, and second, from properly, competently performed illegal or nonhospital abortions.

It is tempting to predict that by the end of this decade, abortion will be a readily available medical service, not only for contraceptive failures and for purposes of sex selection, but, for any woman who states that she does not feel she wants to bear a child at this particular moment in her life. However, I think the more important prediction to make at this time is that nothing will change unless the groups directly concerned, such as Planned Parenthood, medical societies, and nurses working in family planning become, in Howard Taylor's words, "involved and responsible." Nonhospital abortion deaths are totally preventable. The availability of modern contraception and safe hospital abortion should make inexcusable the death of even one woman at the hands of an abortionist. We must finally recognize our medical responsibility to prevent this disease. In order to do this, we must be willing to examine and re-evaluate the relation of abortion to Planned Parenthood. I believe that the thinking of all of us concerned with family planning, and even those of us concerned specifically with abortion problems, has evolved because of our clinical and personal experience. For example, a prominent obstetrician-gynecologist in this city has made his personal position unmistakably clear: illegal abortion is a public health problem; maternal mortality, secondary to illegal abortion, is a totally preventable cause of death; abortion should be included routinely as a recognized method of family planning. Yet, this same individual, when he was a first-year resident in obstetrics and gynecology, absolutely opposed the idea of aborting a 13-year-old girl who had been raped. Most of us who have come to view abortion as a necessary and just form of birth control have passed through a similar evolution in our thinking. I also believe that the time is long past for Planned Parenthood to get involved and be responsible. Women seeking abortions have made a difficult and responsible decision. They must be helped and respected; we can no longer permit them to be hindered, degraded, and treated as criminals.

Dr. Asher is resident in psychiatry at Stanford Medical Center. He was Epidemic Intelligence Service Officer at the Center for Disease Control and Director of Abortion Surveillance in the Family Planning Evaluation Activity in Atlanta from 1968-1970.

The Maudsley Hospital

Elective at the Maudsley

by Alvin A. Rosenfeld '70

THE Institute of Psychiatry of the University of London and its affiliated hospitals, Maudsley and Bethlem Royal, are prominent in English psychiatry. The Institute is the finest non-analytical training center in England, a country where psychiatry was dominated by mental hospitals and neurologists until World War II. This multi-disciplinary center is decidedly research oriented and aims to graduate the "all-round" psychiatrist: clinician-researcher-teacher.

Sir Aubrey Lewis, who was professor of psychiatry from 1945-1966, was primarily responsible for the unity and strength of the Institute, which was created in 1948 when the Maudsley Hospital Medical School became the Institute of Psychiatry. Sir Aubrey stimulated research, and the growth and development of new departments, such as psychology. His contributions led Michael Shepherd, professor of epidemiological psychiatry at the Institute, to say that he "virtually created the institution."

Until a year ago the Maudsley was restricted to post-graduate students. At that time the Institute decided to accept a limited number of medical students to participate in its program. Several medical students from other parts of America preceded me in this experiment, yet when I arrived there seemed to be no definite program or policy about what medical students could do and what responsibility, if any, they were to be given.

Vice Dean J. E. Cooper assigned me to Professor Michael Shepherd's firm (ward). No medical student had ever been assigned to a professorial unit, and as I later discovered, Professor Shepherd was at a loss as to what I was doing there. For that reason, despite my request for my own patients, my first four weeks on the firm were spent observing.

Observing, however, revealed quite early that psychiatry at the Institute differed significantly from what I was familiar with in the States. When a patient is admitted to the Maudsley Hospital, where Professor Shepherd's firm is located, a mental status and a physical exam are done during the first day. The residents, or registrars as they are called in England, are the primary physicians with a senior resident (who has completed three years of training) as supervisor. The consultant (Professor Shepherd on my firm) is brought in on all major decisions and is nominally responsible for all the patients on his firm.

The background of the English psychiatric registrar differs significantly from that of his American counterpart. Almost all the registrars are admitted to the program only after several years of general practice or advanced training following medical school. There were many ex-G.P.'s, a cardiologist who had worked in Nigeria for several years, and a number of men with M.R.C.P.'s (an advanced British medical degree). On the other hand, there was a dearth of registrars with any significant background in psychology, sociology, or anthropology.

Because of this strong medical orientation, an intensive effort is made during the initial physical examination and subsequently to diagnose organic causes of the psychiatric disturbance. Similarly, in much of the teaching, there is an emphasis on the characteristics of a disorder that are helpful in differentiating a functional from an organic illness.

The mental status exam is thought of as a primary tool at the psychiatrist's disposal, much as the stethoscope is to the internist. Though the categories of the mental status exam are routine,, the questions within each category are extensive and, at times, extremely detailed in order to delineate precise symptomatology. Senior registrars claim one should be able to do a good Maudsley mental status in 20 to 30 minutes. I never did one in less than an hour.

The mental status exam is sophisticated, and is based on the descriptive phenomenology originally developed in Germany. After a time at the Maudsley, I became more

careful in describing a patient's symptoms. When speaking of delusions, I was aware of the qualitative differences among various types of delusional systems. For instance, the General Paralysis of the Insane (tertiary lues) patients, who have grandiose delusions, (and I learned that only a small percentage do), often have an unsophisticated delusion such as, "I am a king," with no further elaboration by the patient. It is described as "the delusion of a rotting brain." Elaborate delusions with plots and counterplots are more common in other illnesses, such as schizophrenia. If a person had an auditory hallucination, it was significant to know if it occurred inside or outside his head. If inside, was it an hallucination or just a thought? Was the voice clear? Was the patient in bed at the time? Was it a hypnagogic or hypnopompic phenomenon or a genuine hallucination?

One emphasis at the Maudsley is on this precise descriptive phenomenology with an eye toward using the information for diagnostic classification. Professor Sir Denis Hill, head of psychiatry at the Institute and a famous EEG experimenter, is most insistent on this issue. He will often press a registrar who speaks of hallucinations in his patient for a more extensive description only to find that the "hallucination" is really a delusion. This is more than an academic exercise; it influences the staff 's thinking on the nature, treatment, and prognosis of the illness.

During the ten days following admission, the registrar tries to piece together a picture of the patient's history. He will examine family and personal history, and try to visualize the premorbid personality. He will study school, hospital, and employment records, and any available information from social agencies. Highly skilled social workers help in this investigation, while psychologists do extensive testing, if indicated. The registrar contacts and interviews people who have known the patient at various times and under different circumstances. The aim is to get a picture of the person, his life-style, social relations, interests, standards, and character. With the help of these contacts, the circumstances surrounding the present illness are usually elucidated.

All of this data is put into a case report with a short summary of relevant information. A formulation is written and plans for treatment are discussed. Finally, a prognosis is tendered.

About two weeks after the patient is admitted, he is presented to the ward consultant. The registrar, social worker, psychologist, ward nurse, and any other people involved attend these twice-weekly work rounds. Professor Shepherd first sorts out the information to establish the nature of the problem. He then interviews the patient to elicit information considered relevant to establish a diagnosis. These interviews are skillful and often reveal significant information in a short time. Then the case is discussed with a view toward its management — whether drugs or ECT would be most appropriate.

Before the patient is discharged, plans for future management are discussed. Social service is especially helpful in placing people in hostels and planning rational, hopefully effective social management for the prevention of future hospitalization. Professor Shepherd was often anxious to have the local G.P. manage the post-hospital care.

MY patience with observation paid off after the first month on the firm. Dr. Steven Hirsch, the senior registrar, asked me to do several mental status exams on some of the ward's more interesting patients. One was an idiot-savant, a man with a low I.Q. who could give, with an amazing degree of accuracy, the day of a date in any year for about the past 80 years. He was equally accurate in naming future days. Professor Shepherd requested that I do some reading on the subject of idiot-savants; the exercise was interesting and I later presented a report on my impressions of the literature.

After each of the mental status exams, I reviewed what I had found with Dr. Hirsch, who offered helpful suggestions and ideas. I was still anxious to do an entire workup on my own.

Two weeks later, Dr. Hirsch told me that I would be given a patient, a responsibility no medical student had ever had at the Maudsley. A registrar would have nominal responsibility and countersign my drug orders, but, in effect, I had almost complete responsibility. I went through the steps described above, saw the difficulties, and had an opportunity to exercise the techniques I had been exposed to. Through this I got a feeling for what the Maudsley approach entails. This experience was the high point of my stay on the Professorial Unit, and I am confident that medical students going to the Maudsley in the future will have this opportunity much earlier in their stay.

Whereas Professor Shepherd's rounds were work rounds designed to give some teaching while covering the problems of the ward, Professor Hill gave two rounds each week designed specifically for teaching. The Monday afternoon conference was a multi-disciplinary session dealing with patients of particular interest to all staff members. After the case was presented and the relevant literature discussed by the patient's registrar, the patient was interviewed. If the patient had exhibited bizarre behavior that had been recorded on video-tape, that was shown. Later, all the senior staff were asked for opinions. There was much disagreement because those present ranged from behavior therapists to Kleinean analysts.

The Monday afternoon conference was erudite; the Friday morning conference was practical and informative. It was a registrars' conference and the problems discussed ranged from epilepsy, to character disorder, to bizarre psychosis. One week's conference might require sophisticated reading of EEG's and

The Institute of Psychiatry of the University of London.

pneumoencephalograms; the next might deal with the problems of a drug subculture; and the third might be directed toward a precise exploration of the phenomenology, and often the psychodynamics, involved in a patient's hallucinations.

While inpatient work centered around diagnosis, drug or electrical treatment, and disposition, the outpatient department was concerned with analytical psychotherapy. It is an exception within the Institute of Psychiatry, an institution that struck me as being anti-analytical rather than eclectic, even though Professor Hill has recently taken a more benevolent view of analytic and psychodynamic theory.

Dr. Heinz Wolff and Dr. Henri Rey, both Kleinean analysts, are active in teaching. Together they provide a superb experience for registrars and medical students. There is more give-and-take, more active discussion, and more openness in the outpatient department than anywhere else at the Institute. Both Drs. Wolff and Rey hold supervision groups for registrars conducting individual and group therapy sessions. During the supervision meetings, Dr. Wolff uses many of the same techniques he uses during his own therapy sessions, one of which can be observed weekly through a two-way mirror. He deals with individual problems; at the same time he makes discussion of them relevant to the general issues facing all the therapists. I was continually impressed that Dr. Wolff's warmth and informality came through in this traditionally stiff and hierarchical institution.

In addition to the many supervision groups I could attend, I went to a Wednesday conference chaired by Dr. Rey, and a Thursday session with Dr. Wolff. Both of these were case presentations with open discussion of the psychodynamics of the case, the general principles of psychodynamic theory, and the psychotherapy that each patient showed. Drs. Wolff and Rey are excellent teachers, who invite opinions and impressions from everyone present. There is avid participation with an interesting summation at the end by one of the two men.

Registrars at the Maudsley are preparing for the University of London's degree of Master of Philosophy in Psychiatry. The examination for this is divided into two parts: the first covers neurobiology, psychology, sociology, and genetics; the second includes clinical psychiatry and clinical neurology. The Institute has a lecture series to prepare trainees for these exams. There are lectures on the organic causes of psychiatric illness, social psychiatry, community psychiatry, mental testing, neurophysiology, etc., which vary from poor to excellent. Every Wednesday, there is a lecture of general interest by a distinguished speaker. One Wednesday, Dr. Isaac Marks of the Institute discussed desensitization, a mode of therapy used extensively at the Maudsley and advocated by Professor Eyesenck, the well-known head of the Institute's psychology department. Another lecturer dealt with the promotion of insight, and a third discussed anorexia nervosa. These lectures are lucid and of superior quality, though there are, of course, exceptions. In a three-month period it is possible to cover a wide variety of subjects and be exposed to many areas of psychiatric thought that go unemphasized at home.

In conclusion, the Institute of Psychiatry offers a unique opportunity to become familiar with some aspects of psychiatry, such as phenomenology and aversion therapy, which are not widely taught in the United States. One can get a feel for social psychiatry in England, where it originated. A medical student planning a career in psychiatry will be exposed to an approach he may never encounter at home. He will not get as much psychodynamic theory as he would at an American institution, nor will he see a heavy emphasis on psychodynamically or psychoanalytically-based psychotherapy. Considering the Maudsley's strengths and weaknesses, I feel that it can be a truly worthwhile and meaningful experience for anyone considering a career in psychiatry.

Dr. Rosenfeld is an intern in medicine at Rhode Island Hospital.

EDITORIALS

Mass Abortion: From Nitty-Gritty to Brass Tacks

How refreshing to learn from Duncan Reid that Plato thought in terms of ZPG (zero population growth), and to be persuaded by John Asher that the 17th century concept of the fetus as a "little man" (homunculus) is clearly more logical than the complicated sequence with which we are now familiar! They remind us that those who pass over old ideas as quaint are also apt to dismiss new ones as absurd. At the same time they lead us to the nitty-gritty of a confrontation with a new idea: mass abortion.

If mass abortion for the purpose of population control is to become public policy, it first must be demonstrated that it is necessary. We must be convinced that our cultural survival demands it, and that other measures, which might be simpler, (better contraceptives and abortifacients) will be too long in coming to do the job. The defenders of present contraceptive methods might well argue that existing products are undersold and underutilized, and that the principal effect of an effort to sell the concept of abortion would be to awaken the public to the need for contraception. The proponents of abortion, on the other hand, might reply that this, in fact, was their intention. It is indeed likely that every woman aborted and then instructed in contraception would become an advocate for the latter.

Medical history teaches that there is a considerable lag in time between the demonstration of clear necessity and the enactment of public policy. As Davis and Olmsted showed in the May-June issue of the *Bulletin* it took more than 20 years to decide to get rid of herds of tuberculous cattle, a small step in comparison with performing a million abortions a year. Such a lag in the case of mass abortion might carry us into the era of the perfect anti-fertility agent, but also, unfortunately, well into the population explosion.

Medical history also gives us an interesting example of a simple solution that failed, and a cumbersome solution that triumphed and has been used ever since. Over a century ago the mortality due to surgical infections in urban hospitals was enormous; surgery performed in the home carried far less risk. While Lister was devising his cheap and simple carbolic acid spray, his father-in-law, Syme, was urging that urban surgical services be disbanded and "cottage hospitals" be set up throughout Great Britain. Today we can smile comfortably at Syme's notion, and dismiss it as an example of burning down the house in order to roast the pig. The choice between a simple solution for surgical sepsis and a cumbersome one recurred later on, however, with somewhat different results. At the beginning of our century we find that one of Lister's disciples learned the lesson of the simpler solution a little too well: he inveighs against "lesser men" who advocate complicated, expensive and obviously impractical machinery for surgical sterilization, and will not be content until "a boiled surgeon operates on a boiled patient in a boiled operating room." (In order to use his carbolic spray, Dr. Lister, it appears, did not "get himself up to operate like a mummer at a carnival — he looked like a human being"). And today, 60 years later, we take the expense of surgical asepsis, astronomically greater than that of "cottage hospitals," for granted. If the "simple solution," the magic antiseptic spray or ray, were at last to appear, would our surgeons still feel like surgeons without their masks, gloves and other mummery?

Today we must ask whether the cumbersome solution (mass abortion) belongs to the category of Syme's "cottage hospitals" or to that of surgical asepsis by means of steam sterilization. Mass abortion would be a wholly new medical service that would require a new and revolutionary attitude for many. Drs. Asher and Reid have brought us to the nitty-gritty of the problem, but not to the brass tacks: cost-benefit analysis, amortization of the program. Surely the cost per bed of mass abortion can be made a fraction of that necessary for other hospitalization, this being achieved in part through the utilization of paramedical personnel, in part through the utilization of space, not necessarily in hospitals, which would not need to be newly built. The units so used could logically also be centers for family planning; this function could continue after progress in contraception rendered mass abortion obsolete. The program would, of course, effect a significant saving in prenatal and obstetrical care. Who should be involved, the government or private enterprise? Negative images can be associated with either: on the one hand, a governmental agency as a shabby building in the ghetto where a crude attempt at genocide incurs more governmental spending and large deficits; on the other, an "abortion palace" as a wing of the country club in a privileged suburb, with financial bonanzas for a few. Dr. Reid's "cottage hospitals" would be regulated by the federal government, and he offers cogent reasons for this proposal: paramount among these is the need for high and uniform standards of care.

Dr. Reid's figure of 1-1.5 million abortions could be accomplished in 400 10-bed units, performing 10-15 abortions a morning for 50 weeks of the year. The scale of such an operation would not seem frightening to a moderately ambitious motel chain. As with contraception, the largest problem, even more among ourselves as physicians than among our potential customers (do we need to call them patients?), is the morality of the

thing, or, in modern terms, the *image:* if it is necessary to regulate our population growth by means of abortion we must come to feel that it is also fair and good.

GEORGE S. RICHARDSON '46

"The Maudsley"

"One simple fact, rightly understood and truly interpreted," wrote the English alienist, Henry Maudsley, in 1870, "will teach as much as a thousand facts of the same kind, but the thousand must have been previously observed in order to understand truly the one." That the present incumbents of the institution that bears his name share Maudsley's enthusiasm for empirical observation is amply attested to in a delightful and informative article by Alvin Rosenfeld '70, printed elsewhere in this issue of the *Bulletin.*

During the elective period of his fourth year, Dr. Rosenfeld had the opportunity to spend two months as a student on the wards of the Maudsley Hospital, a clinical facility of the Institute of Psychiatry of the University of London. Long restricted to the training of graduate physicians in the specialty of psychiatry, the Maudsley has recently opened its doors to medical students, and Dr. Rosenfeld was one of the first to avail himself of the new curriculum. What he found there should be shared with all American medical students interested in psychiatry. As Dr. Rosenfeld makes clear, the emphasis at the Maudsley is on fact and observation, and on a rigorous training in the nature and description of clinical psychiatric phenomena — an approach less widely stressed in the United States, where the equally important concerns with psychodynamic processes have until recently held the center of the stage. At the same time, through his participation in the work of the outpatient clinic, the student is able to gain a thorough exposure to the principles and techniques of dynamic psychotherapy.

Dr. Rosenfeld's evident enthusiasm for his English experience is easy to understand. He was privileged to be taught by men who are numbered among England's most distinguished psychiatrists. He was exposed to the discipline involved in the careful and painstaking observation of behavior and in the systematic ordering of clinical facts — a discipline invaluable to any student of psychiatry. He had the chance to observe the practice of medicine in another land, that, seemingly so similar, is in many ways so foreign to our own. And — a "simple fact" to be "rightly understood and truly interpreted" — he learned the endless pleasure of London, her people and her pubs.

JOHN C. NEMIAH '43B

Tragedy of the Redwoods

In view of the articles by Porter and Wayburn on conservation, published in the March-April 1970 issue of the *Bulletin,* and the editorials that accompanied them, the subject of conservation of the environment may be pursued a step further. The incentive is found in the publication by the Sierra Club of a new, profusely illustrated book, *The Last Redwoods and the Parkland of Redwood Creek,* in the preparation of which Dr. Wayburn and his wife Peggy have been leading spirits. The photographic illustrations are superb — even where they tragically reveal the effects of "clean" logging, which, like strip mining, destroys not only the ground cover but the soil itself, left open to and unprotected from the eroding elements.

The picture of one such raw wound includes the smugly apologetic signboard:

> Overmature timber harvested here in full compliance with California forest practice laws and regulations. Helicopter sowed 21 million seeds to start a new forest January 1965. 58% Redwood, 24% Spruce, 18% Douglas fir.

It gave no estimate of the seeds' chances of survival in the newly created wasteland, nor did it mention the fact that it would take the redwoods about 400 years to reach a stage of maturity that would make them a good marketable crop — nor what other form of life may have supplanted man at that remote time.

"Any fool can destroy trees," John Muir is quoted as having once written . . . "God has cared for these (Sequoias), saved them from drought, disease, avalanche, and a thousand straining, leveling tempests and floods; but he cannot save them from fools — only Uncle Sam can do that." It would, of course, be inconceivable to think of Uncle Sam as the greatest fool of them all, but already 90 percent of the redwoods are gone, and only three percent of those remaining are protected.

Reprinted in *Massachusetts Audubon* for March 1970, from *The Nation,* 29 December 1969, is a challenging article "The Vandal Ideology," by the Reverend Scott Paradise, executive director of Boston Industrial Mission. "Not only must our industrial system be changed," he asserts; "the system of belief about man's relationship with the natural world which underlies it must be corrected if we are to escape the jaws of the coming crisis."

He reduces the current American ideology of man and nature to seven propositions: that man is the source of all value; that the universe exists only for man's use; that man's primary purpose is to produce and consume; that production and consumption must increase endlessly; that material resources are unlimited; that man need not adapt himself to the natural environment, since he can remake it to suit his own needs; and that a major function of the state is to make it easy for individuals and corporations to exploit the environment to increase wealth and power.

In general man is faced with the unavoidable ultimatum of conserving what remains of his heritage

and restoring, where it is possible, that which is not yet utterly destroyed. So far as the redwoods are concerned — and they are only one example among many — there is now a race on between those who would save some parts of our natural environment unravished and those who are bent on its destruction for the immediate dollar value, before the legislators can be persuaded to act more forcefully.

The profiteers are no doubt often kindly men, outside of business hours, and devoted to their families, but it is nevertheless difficult to persuade many of them that they must abandon their path of destruction if the earth is to remain habitable.

There are, fortunately, many signs that an impulsive younger generation, for the most part generously motivated, may yet rescue from the spoilers the environment in which they are to live. Conscious of the pollution and environmental desecration that surrounds them, they are cleaning up streams, eliminating unauthorized dumps, salvaging usable material gone to waste, and fighting for purer air to breathe.

Along the Perimeter

HCHP's New Executive Director

The former director of enrollment for the Kaiser Community Health Plan of Cleveland, Robert L. Biblo, has been named executive director of the Harvard Community Health Plan.

The Harvard Plan is a non-profit, pre-paid comprehensive health plan now enrolling members in the Greater Boston area.

Mr. Biblo, who joined the HCHP in December 1969, succeeds Professor Jerome Pollack who resigned to devote full time to his academic and administrative responsibilities as professor of the economics of medical care, and associate dean of the Faculty of Medicine for medical care planning at HMS.

On taking over his new duties, Mr. Biblo announced that the HCHP has entered into a contract with the Massachusetts Department of Public Welfare to offer medical care services to those persons eligible for Medicaid residing in Boston's Mission Hill-Parker Hill area, the care to be financed on a pre-paid per capita basis.

He further disclosed that the HCHP has received a grant from the USPHS that will enable the plan to supplement health insurance premium payments to those in the same area whose income is just above the Medicaid maximum, but who are unable to avail themselves of comprehensive medical care. Allocations from the supplemental program will be based on income and family size.

Mr. Biblo also announced that a medical "Outreach Center" had been opened in the Mission Hill area. It will provide primary medical care of a non-emergency nature, in addition to referral information for social services, and a child's sitter service to enable mothers to visit social agencies or the HCHP center for medical care.

Studies are in progress to establish services through hospitals located in outlying communities. Cooperating hospitals are the Beth Israel Hospital, Peter Bent Brigham Hospital, Boston Hospital for Women (Lying-in Division), and the Children's Hospital Medical Center. The HCHP is the first comprehensive health plan in the nation to have the full cooperation of a medical school and its affiliated hospitals, which guarantee physicians and hospital services. There are 25 physicians providing medical care in the HCHP, eight of whom are full time.

The HCHP is underwritten by eleven insurance underwriters. They are; Massachusetts Blue Cross, Aetna Life, Connecticut General, Equitable, John Hancock, Liberty Mutual, Massachusetts Mutual, Metropolitan, Prudential, Travelers, and Union Mutual. Each of the underwriting firms, which offers HCHP as an alternate to subscribers, believes the Plan will provide many answers to critical health care problems, among which are rising medical costs, physician shortages, and the fragmentation of health services.

Shattuck Professor

Benjamin Castleman, M.D. has been named the sixth incumbent of the Shattuck Professorship of Pathological Anatomy. He will continue to serve as chief of the department of pathology at Massachusetts General Hospital.

Internationally known for his research and teaching, and for his administrative and organizational abilities, Dr. Castleman's medical interests have been concerned with diseases of the parathyroid and thymus glands, pulmonary embolism, infarction, renal biopsies in hypertension, pulmonary alveolar proteinosis, and polyps of the gastrointestinal tract.

Dr. Castleman received the M.D. degree from Yale in 1931. He is a member of the American Association of Pathologists and Bacteriologists, American Society of Experimental Pathology, American Society of Clinical Pathology, and the International Academy of Pathology (president, 1962). He is the editor of the Case Records of Massachusetts General Hospital, published weekly in the *New England Journal of Medicine*.

The Shattuck Chair was established in 1853 through a gift from Dr. George C. Shattuck. Dr. Castleman succeeds Arthur T. Hertig '30 who has assumed new responsibilities as professor of pathology. Dr. Hertig is chairman of the division of pathobiology at the New England Regional Primate Research Center.

Henry Isaiah Dorr Professor

Richard J. Kitz, M.D. has been named the second incumbent of the Henry Isaiah Dorr Professorship of Research and Teaching in Anesthetics at Harvard Medical School. He is also head of Harvard's department of anesthesia at the Massachusetts General Hospital, where he serves as chief of anesthesia.

A clinician-scientist-teacher, Dr. Kitz has been professor of anesthesia since 1969. Prior to his joining the HMS faculty, he was associate professor of anesthesiology at Columbia University College of Physicians and Surgeons, and associate attending anesthesiologist at Presbyterian Hospital.

Dr. Kitz received the M.D. degree from Marquette University in 1954. He is chairman of the Committee on Pharmacology and Neuromuscular Transmission, Scientific Council, American Society of Anesthesiologists. He is a diplomate of the American Board of Anesthesiology, a fellow of the American College of Anesthesiology, and a member of the New York Academy of Medicine, American Chemical Society, and Association of University Anesthesiologists.

The Dorr Professorship, the oldest endowed chair of anesthesia in the world, was established by the University in 1917 through a gift from Henry Isaiah Dorr.

Dr. Kitz succeeds Henry K. Beecher '32 who has become the Henry Isaiah Dorr Professor, emeritus.

One of Dr. Beecher's major interests has been the ethics of human transplantation, a field in which he has made significant contributions. His major research has been directed to investigations analyzing the effectiveness and safety of anesthetic and pain-relieving agents. He has studied the possible relation between personality types and drug effects and was one of the first to insist on the possibility, and necessity, of a quantitative approach to subjective responses. As a result of this work, he has been acclaimed as one of the founders of psycho-pharmacology.

He is a member of the Association of University Anesthetists, American Surgical Association, American Physiological Society, and the American Society for Pharmacology and Therapeutics. He received the Oscar B. Hunter Memorial Award of the American Therapeutic Society in 1961, the German Medical Prize in 1963, and the Waters Medal in 1970.

Richmond Assumes Psychiatry Posts

The former dean of the medical faculty of the State University of New York at Syracuse, Julius B. Richmond, M.D., has been appointed professor of child psychiatry and human development at Harvard Medical School, director of the Judge Baker Guidance Center, and psychiatrist-in-chief at the Children's Hospital Medical Center.

As the first director of Project Head Start in the Office of Economic Opportunity and later, as director of health affairs for the OEO, Dr. Richmond developed the concept of the organization's funded comprehensive health clinics, which was highly regarded as a major new model for the delivery of health care. For his services, he received the Distinguished Service Award from former President Lyndon B. Johnson.

While in Syracuse, Dr. Richmond established and served for a time as co-director of a pioneering day care center that accepted infants as young as six months. His plan has been adopted elsewhere in the nation.

Academically, he is held in high regard by both his contemporaries and students as an outstanding teacher, investigator, and administrator. His career has spanned nearly every area of child health and development, and reflects his continuing interest in social medicine.

Dr. Richmond received the M.D. degree from the University of Illinois in 1939. He has served as president of the American Psychosomatic Society (1962-63), and of the Society for Research in Child Development (1967-69). He was vice president of the Society for Pediatric Research (1961-62), and of the American Orthopsychiatric Association (1966-67). In 1964, Dr. Richmond was chairman of the Expert Committee on Adolescence, World Health Organization, and in 1965, was vice president of the Joint Commission on Mental Health of Children.

Dr. Richmond succeeds George E. Gardner '37 who has become professor of psychiatry, emeritus, at Harvard Medical School. Dr. Gardner has been director of the Judge Baker Guidance Center since 1941, and psychiatrist-in-chief at CHMC since 1953.

Dr. Gardner has played a leading role in the development of child psychiatry in the United States. His studies have encompassed the period of adolescence and problems of juvenile delinquency, aggression, and the emotional health of both normal and troubled youth. He has brought to his students a useful knowledge of the growth and development of the human personality.

He was one of the founders of the American Academy of Child Psychiatry and, with Dr. Douglas Thom, made Massachusetts a focal point in the nation for training in the area of child psychiatry. He is a former president of the American Association for Child Psychiatry and of the International Association for Child Psychiatry and Allied Professions.

In 1968 he received the Agnes P. McGavin Award from the American Psychiatric Association "for contributions to child psychiatry." He is a diplomate of the National Board of Medical Examiners, and a diplomate in psychiatry of the American Board of Psychiatry and Neurology.

Two Professorships in Ophthalmology at MEEI

Henry F. Allen '43A has been appointed the Henry Willard Williams Clinical Professor of Ophthalmology at HMS. He is chief of the department of ophthalmology at Massachusetts Eye and Ear Infirmary, and chairman of the department of ophthalmology at HMS.

An outstanding clinician, he has provided medical care to the Sioux Indians in South Dakota and to the natives of Pucallpa, Peru, reflecting his concern for those unable to get professional eye care. In 1967 he received the Lucien Howe Medal for outstanding contributions to ophthalmology. He has been editor-in-chief of the *Archives of Ophthalmology* since 1966.

The Williams Chair was established in 1893 through a gift from Dr. Henry W. Williams "for the maintenance of a professorship in ophthalmology." Dr. Allen, as the seventh incumbent, succeeds David G. Cogan '32.

David G. Cogan '32, director of Harvard's Howe Laboratory of Ophthalmology at the Massachusetts Eye and Ear Infirmary, has been named the first incumbent of a newly established professorship in ophthalmology in the Faculty of Medicine at Harvard. The new professorship was established by the University for teaching and research in the field of ophthalmology, the funds provided jointly by The Scaife Family of Pittsburgh, and The Permanent Charity Fund, Inc. of Boston, which is the third largest municipal charitable endowment fund in the United States.

Internationally recognized as one of the foremost contributors to modern ophthalmic knowledge, Dr. Cogan has directed his energies primarily toward basic and clinically-oriented research on the eye. His investigations at the Howe Laboratory have been diversified; the most extensive and significant being the physiology and pathology of the cornea, abnormal fat formation in ocular tissue, the neurology of the ocular muscles, the histology of the eye, and the effects of radiology on the eye. He is author of *Neurology of the Ocular Muscles,* considered by ophthalmologists and neurologists as a comprehensive guide to this complicated subject. Two syndromes bear his name: Cogan's syndrome (1), which describes characteristics of nonsyphilitic interstitial keratitis; and Cogan's syndrome (2), which is concerned with conjugate gaze paralysis.

Dr. Cogan received the Howe Medal of the American Ophthalmological Society in 1965, and the Research to Prevent Blindness Trustees Award for Outstanding Achievement in January 1969. He was also named to the first National Advisory Eye Council of the newly established National Eye Institute, National Institutes of Health, in 1969.

He is a fellow of the American Academy of Arts and Sciences, a member of the American Society of Clinical Investigation, the American Board of Ophthalmology and Otolaryngology, and the American Ophthalmological Society. Dr. Cogan served as editor-in-chief of the *Archives of Ophthalmology* from 1960 to 1966.

Minority Recruitment at HMS

The Harvard Medical School is witnessing its third year of active recruitment of minority group students. An abbreviated recruitment effort, initiated two years ago, resulted in 128 applications from mostly black students representing a five-fold increase over the past. Of these, 16 became members of the Class of 1973.

Last year, after active recruitment by black students and members of the faculty, we received 142 applications. Included in this group were a number of Mexican-Americans and American Indians. The first year class that entered this September has 23 minority students, including one Chicano and one Cuban. In addition, one black and two Indians were accepted as special students to take a year of additional preparation before entrance to the Medical School.

The Harvard Health Careers Summer Program for minority college students, which just completed its second successful year, has also aided the recruitment drive.

As usually happens, Harvard has once again been accused by other medical schools of taking the "cream-of-the-crop" of the minority applicants. However, with new vision and flexibility, the Medical School has ventured beyond the "traditional" type of student. This has offered a new challenge and broader perspective to the entire Harvard Medical community.

This coming year, in order to ensure a growing number of minority applicants, Harvard is mounting another recruitment effort. We have combined in a joint effort with the Dental School, School of Public Health, and the Graduate Division of Medical Sciences to seek qualified applicants. Currently, recruitment teams, made up of faculty members and minority students, are visiting colleges throughout the country. A special effort will be made to attract applications from Chicanos, Indians, and Puerto Ricans. This recruitment drive will ensure us of a larger number of applicants from whom to select those showing the greatest promise.

As always, Harvard Medical Alumni have been helpful in referring attractive minority group candidates to the Medical School. This year we hope that the Alumni will increase their participation in recruitment. Any help they can give through personal contact at colleges or from associations with community groups will be greatly welcomed!

Alvin F. Poussaint, M.D.

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Letters

Land of the Free

To the Editor:

I rarely indulge in public display of my socio-political emotions by writing to "The Editor," but the letter by Frank Fowler '23 in the March-April 1970 *Bulletin* demands a response.

I want to go on record praising Dean Ebert for participating in the peace demonstration, for acting on his moral principles, and for using his constitutional right to be heard and to be counted among those who want to preserve a democratic society. I suggest that Dr. Fowler reread the Declaration of Independence and the Preamble to the Constitution to refresh his memory concerning the freedom that once was taken for granted, and which he labels "disgusting."

Dorothee L. Perloff '54

To the Editor:

I would like to answer Dr. Fowler's letter that appeared in the March-April 1970 *Bulletin,* to tell him that I am one graduate of HMS who disagrees strongly with the sentiments he expressed.

I suggest that Dr. Fowler put down his medical journals for a moment and read the Constitution of the United States of America, paying particular attention to the first ten amendments.

Cyril J. Jones '44

To the Editor:

Hurrah for Dr. Ebert and his effort vis-a-vis the Vietnam Moratorium! Although Dr. Pollock, in the May-June 1970 *Bulletin*, would like to have us think that politics is separable from life and work, both he and Dr. Ebert have proven that such a thing is impossible. Dr. Pollock doesn't really disagree with the form of Dr. Ebert's activity, that he "got involved in politics," but with its content, that is, Dr. Ebert is against the Vietnam war. It must be remembered, (and Sir Thomas More lost his head over this issue), that choosing not to do something is just as much a political act as is choosing to do something. If Dr. Ebert had chosen not to get involved with the Moratorium, Dr. Pollock wouldn't be complaining, but that would have been as much of a political act on Dr. Ebert's part as was his choosing to get involved. To say that one disagrees with Dr. Ebert's position on the war is one thing, but to complain that medicine and politics don't mix, that Dr. Ebert is "unseemly" in his behavior, is arrant nonsense.

Steven Jonas '62

Editor's Note: A brief comment on the 15 October 1969 "Moratorium Day" having appeared in the November-December *Bulletin* of that year, and Dr. Fowler's equally brief letter six months ago, it may be fitting to allow Dr. Jones's and Dr. Jonas's letters to close the discussion.

Rebuttal

To the Editor:

We would like to comment on Mr. Mason's article, "A Radical View of HMS and Related Matters," (*Bulletin,* May-June 1970).

It is very disturbing to see events reported in the alumni journal with such disregard for the audiences' possible interest in what might really have gone on. It would be difficult and space consuming to list each and every distortion and omission but two examples should make our point.

Notice first of all that outside of Mr. Parks of the Roxbury Tenants Association, only non-speakers names were mentioned. Evidently, if you are not a well-known personality or a faculty member, you should expect a member of the administration to ignore your identity and to feel free to twist your presentation to make his article sound cute.

A very clear example of Mr. Mason's selective perception is in the account of the talk that one of us gave. He suggested that Dr. Mikulecky had, for the first time, discovered the value of collaborating with technicians in his lab. In fact, what was said was that there had been an attempt to gain technicians and other non-faculty a vote equal with faculty in managing the lab. The reference to painters was made to verify claims of SDS that the hiring of qualified black painters as helpers was both racist and a mechanism for lowering the pay of all painters in the long run. After people in the lab were encouraged to speak to the painter (white) and the helper (black) they were led to accept the SDS position.

Another example is the description of the talk given by Dr. Rita Arditti. The speaker made a presentation analyzing the concept of child care from a Woman's Liberation perspective. She stressed the idea that society and the institutions who run it have to begin to accept their responsibility for the rearing of children. The particular role of universities in creating and perpetuating male supremacist ideology was illustrated with examples drawn from the Harvard faculty. Harvard, as an employer, is, in this respect, seriously lacking, since even industries like KLH in Cambridge have recognized the need for child care and have their own child care centers. The

type of child care center, its relation to the community outside the university, and the possible dangerous ways in which a child care center could be used (for instance, tying a woman into a frustrating and repetitive job) were discussed. Dr. Arditti also presented a set of demands to change the status of women at Harvard. The only thing, however, that Mr. Mason got was that "the lady" wanted a 24-hour day care center, and that Harvard and Radcliffe opposed day care centers.

What is also very unfortunate about Mr. Mason's presentation is that it will help to maintain the illusions among alumni that all is well at Harvard, and that any problems arise from a small clique of radical trouble makers. Alumni are thus left in a very poor position to understand what is going on at Harvard today.

One impression shared by many of us who have tried to deal with the HMS administration about relevant social issues is the ease with which deception is used in dealing with people. Coming from a member of the administration, Mr. Mason's article is another example of such practices.

And so much for the distortions and inaccuracies. We have only discussed two cases but the same is true for the rest. But distortions and inaccuracies are not all that is wrong with Mr. Mason's article. What is essentially wrong is Mr. Mason's insulting and snobbish tone. He calls the teach-in, "this affair" and says ironically that he could not "resist" a poster guaranteeing the appearance of a speaker from the Roxbury Tenants of Harvard Association. He again calls the meeting "this year's show" and qualifies it as a "trade union kind of thing." He describes some of the speakers as "feature attractions" and refers to Mr. Parks as giving a "Reader's Digest condensed version of the HMS struggle to oppress the poor whites of Roxbury," and says "it was beautiful" with obvious sarcasm.

Mr. Mason gives the reader the impression that he feels himself above all this nameless crowd. He does not go to the meeting to find out what the problems are, why people are unhappy, and what tentative solutions are proposed. He goes to make fun of this effort and by such attitude exemplifies the worst aspect of Harvard's attitude: its lack of respect for anything but so called academic standards, and its lack of sensitivity for the needs of people.

Rita Arditti, Ph.D.
Associate in Bacteriology and Immunology, HMS
Donald C. Mikulecky, Ph.D.
Lecturer on Biophysics, HMS

The above letter was submitted to Mr. Mason, who offers the following comment:

To the Editor:

There are many responses to the Radical Movement. One may write scholarly pieces, such as those done by Ken Keniston or Leon Eisenberg, and there is no paucity of these. One may also become quite angry and do a Bettelheim type of article. Or one may, on occasion, adopt an attitude of frustrated amusement. The humorlessness of the radical left is a psychic matter of its own and, indeed, may underlie much of the violence they precipitate in the name of non-violence. Social ills certainly are not humorous, but they cannot always be resolved by the self-righteous. This particular meeting abounded in half-truths, zealous polemics, and an absence of discussion. Its genre has become a tiresome part of the Harvard scene and threatens constructive reform. The radical left has a tragic/comic aspect which cannot be ignored, but which Dr. Arditti and Dr. Mikulecky seem unable to recognize.

Bayley F. Mason
Associate Dean for Resources, HMS

Doctor Afield

To the Editor:

Having abandoned the pursuit of medicine (one of the professions for which I was trained) almost to the point of being listed as "lost," I wish now to go on record as being very much among the living, and offer the following to bring myself up to date as a bona fide member of the Class of 1920.

Education

English High School
M.I.T. - Bachelor of Science
Harvard Graduate School of Arts and Sciences - Master of Arts
Professor Baker's Workshop
Harvard Medical School - Doctor of Medicine
Ecole Cesar Franck, Paris - 3-year Degre Superieure in Music, as Conductor, Composer

Career

During my high school and college days, I earned my tuition playing in orchestras in such places as the Ocean House in Swampscott, and later with my own orchestra at debutante parties and weddings in the various hotels in town, passing from child-prodigy violinist to the role of orchestral conductor in rather rapid stages.

By the time I was ready for my medical career, my earnings as a conductor and impresario for several of my own orchestral groups was so fabulous that the practice of medicine was something to postpone to a "less" propitious time, particularly as my training had always had research in psychology and psychopathology as its primal focus.

And so it was that Dr. Dolphe Martin Eisenbourg became, on the marquees of various theaters where I would appear, "Dok Eisenbourg and His Sinfonians." This was the name that was heard daily in the early days of radio on Station WNAC. But Science did have its part during this period, when I collaborated with Dr. Leonard Troland. In Europe I conducted at the opera house in Montmartre, and wrote a score for a film called, "Safari." In

Spain I found a play by Pinillos, which I saw in Granada, and securing the foreign rights, I translated it, and brought it back to the States for production.

Then came the advance from pioneering days in music, when my early orchestral style was imitated by others, and even influenced the great Paul Whiteman, as he himself confided to me in a moment of expansive camaraderie.

Under contract to CBS, I became Dolphe Martin, where one of my first assignments was a national broadcast series for the Tydol Company, which I conducted (my own orchestral group and not the station's), and for which I arranged the music. Gathering under my baton such outstanding musicians as Benny Goodman, Tommy and Jimmy Dorsey, Eddie Duchin, and others, we created one of the most magnificent sounds ever heard on radio. Later these same men branched out to become leaders in their own right, and with their own orchestras.

It was at this time I veered away from the stereotyped conventional music, and created a new sound — the voice orchestra. Collaborating with the Pulitzer Prize winner, Paul Green, I composed the music for what we called an operatic drama, known as "Roll Sweet Chariot." When it was produced at the Cort Theatre in New York, it was universally acclaimed by the critics, and such celebrities as Albert Einstein and George Gershwin came down to look into the orchestra pit where I was conducting my voice orchestra to verify that they were indeed voices and not instruments performing orchestrally, so uniquely did I interweave 38 voices and only three musical instruments — a clarinet, string bass and trombone.

Then followed the period when I became the producer-director of a national network program on Radio CBS, called "Youth on Parade," which in turn became one of the most popular TV shows in New England.

But medicine always had a place in my heart and mind. So, combining my two loves, medicine and music, I opened a school in Boston under the aegis of the Veterans Administration, wherein I established courses for the emotional rehabilitation of disturbed veterans, through music and drama. This innovation in therapeutic teaching proved highly successful, achieving tremendous results, even in advanced states of emotional disturbance.

Soon came normal students who wanted to take advantage of these unusual training courses, with the result that I had to expand.

Thus, in association with the KC-Martin Productions, we opened the West Roxbury Academy for general enrollment. Here, many of the performing arts were taught, with my role being that of head of the department of specialized training for emotionally disturbed youngsters. The Academy was eminently successful, and I had achieved the goal of uniting my two loves — music and psychology — a marriage which produced, as the offspring of a bachelor named Dolphe Martin, hundreds of talented youngsters.

Looking back on my career with a deep sense of gratification, I can experience the utmost in joy and happiness, knowing that such outstanding personalities as Benny Goodman; Ruth Casey, the TV star; James Lawton, Judge of the Brockton Court; and Eliot Silverstein, film director and Academy Award winner, as well as countless others, were in a way my own professional progeny.

This symbiosis of medicine and music created a little universe of its own, in which the soul of a humble boy-violinist grew to fine stature and a highly rewarding maturity and fulfillment.

DOLPHE MARTIN '20

book REVIEWS

Founders of the Harvard School of Public Health: With Biographical Notes 1909-1946 by Jean A. Curran '21. 294 pages, illustrated. New York: Josiah Macy, Jr. Foundation, 1970.

Dr. Curran, in preparing and presenting the detailed story of the founders and the establishment and development of the Harvard School of Public Health, has performed an arduous service for which he and the School can be congratulated. It has been a six-year labor, begun after his retirement, but he has not faltered on the way, or seemed to have lost any of the remarkable energy and interest with which he began it.

It is a sad commentary on the devious ways of mankind that between the filing with the legislature of Lemuel Shattuck's now famous "Report of the Sanitary Commission of Massachusetts" in 1850 and the finding of it by Henry I. Bowditch in the State House attic, 19 years had elapsed, and another 44 years were to pass between the organization of the Massachusetts Board of Health in 1869 and the establishment by Harvard University and MIT in 1913 of the first School for Health Officers in the United States.

A half century later Dr. Curran was commissioned to tell the story of the School of Public Health.

The original founders of the School for Health Officers were George Chandler Whipple, Gordon McKay Professor of Sanitary Engineering at Harvard University; William T. Sedgwick, Professor of Biology and Public Health, Massachusetts Institute of Technology; and Milton Joseph Rosenau, Professor of Preventive Medicine and Hygiene, Harvard Medical School. To these may be added President Lowell, Theobald Smith, Dean Bradford, Dean Edsall, as the School became solely a Harvard project in 1922, Roger I. Lee, Cecil Drinker and the many others who saw that the task

of organization went forward.

Part I of the book is on Administration; Part II is divided into chapters on departments, a division that has entailed an occasional unavoidable repetition, which is kept to a minimum.

As Dean Snyder writes in his foreword:

> This is Jean Curran's book, to which he brought the affectionate interest of a Harvard-trained physician . . . and the perspective of a long career in medical affairs, ranging from missionary work in China (1923-30) and many consultative assignments abroad to the presidency of Long Island College of Medicine (1942-50), the deanship of the State University of New York College of Medicine at New York City (1952-54), and the trusteeship of the Bingham Associates Fund of Massachusetts (1957--). Author of several books relating to education in the health professions, he is to be commended with gratitude for this latest work.

J.G.

The New Handbook of Prescription Drugs by W. Richard Burack. 362 pages. New York: Pantheon Books, 1970. $7.95

The New Handbook of Prescription Drugs is merely a continuation of the theme and philosophy presented in the original edition — drug manufacturers are "bad guys" who take advantage of the poor helpless doctor.

The book contains four chapters entitled Basic Drugs, Prescription Drug List and Price List, in addition to four appendices containing such information as prescribing for children, the top 200 drugs prescribed in 1967, and a partial listing of distributors of generic drugs.

The New Handbook is skillfully written. The author uses words in such a manner as to imply one thing when, in effect, another situation actually exists. Consider the following: "No generic company with a seriously bad record has been included — (page 284)." The impression the author tries to make here is that the generic drug manufacturers listed in the New Handbook are companies with acceptable records of performance. In reality, the sentence means that these firms have bad records but, in Dr. Burack's opinion, *not bad enough* to eliminate them from his listing. This is understandable; had he eliminated those that have bad, as well as seriously bad, records he might have wound up with no listing at all.

Other parts of the book tend to be equally misleading. For example, Dr. Burack makes reference to the fact that prescription drug containers are unlabeled. Although it is true that he defines his concept of labeling, some lay readers might come away with the impression that drug containers have no labels whatsoever. Instead, Dr. Burack should make reference to the fact that the drug containers, as they leave the pharmaceutical manufacturer, must comply with a detailed "seven-point label." If the prescription drug container does not bear the name of the ingredient, only the physician is to blame. Every pharmacist is willing to place the name and strength of the active ingredient on the container if the physician so requests it.

Dr. Burack also presents the one-sided story that generic drugs are equivalent to brand named products, and are less costly. He does not make any reference to the fact that drugs may differ due to biological or physiological availability of the drug from the blood stream. He appears to imply that chemical equivalency is all that is necessary. This view is not unanimous in the United States today. Consider the following:

> Mr. Max Feinberg of the Department of Defense has stated that "the evidence that is accumulating in the pharmaceutical community is currently demonstrating that a new dimension has been added in determining the quality of drug producers. Chemical testing, without a reference point to biological availability, may no longer be a valid index of quality for a growing list of drugs. Until recent years, compliance with the official compendium was indicative of product suitability. As failures in biological availability are detected and recorded, despite compliance of products with the requirements of the U.S.P. or the N.F., we must, therefore, rapidly maximize our efforts to establish standards reflecting acceptance levels of purity, quality, and effectiveness."
>
> Dr. Charles C. Edward, Jr., Food and Drug Commissioner indicated that methods must be found "for determining not only uniform bioavailability from dosage forms produced by different manufacturers, but also different batches of dosage forms by the same manufacturer."
>
> Thomas J. Macek, Director of U.S.P. Revision recognized the issue when he stated: "I think that now bioavailability specifications for drug products, based upon tests conducted in vivo, begin to focus more sharply into view — Drugs are seldom administered as pure chemical compounds; they are almost always given in some kind of formulation. Accordingly, it is erroneous to assume that the formulation will not influence drug action."

Insofar as drug costs on the whole are concerned, the American Enterprise Institute reports that between 1965 and 1969 costs of prescription drugs to the consumer dropped 1.4 percent in an era when hospital costs climbed 46.6 percent, physicians' fees up 20.4 percent, and dentists' fees 18.7 per cent.

The book therefore cannot be used to "effectively cut your bills for medications." The decision as to what drug the patient is to use remains with the physician. He is legally and ethically bound to exercise sound judgment in reaching this decision. To rely on price data alone would be a mistake.

The book cannot be recommended as a textbook for medical students, nor as a drug compendium for the discriminating physician, and certainly not as a guide for patients to use in shopping for drugs.

WILLIAM E. HASSAN, JR.
DIRECTOR, PETER BENT BRIGHAM HOSPITAL